CALIFORNIA DEPARTMENT OF Mental Health

2011 COMMUNITY MENTAL HEALTH SUMMER STAKEHOLDER SERIES
DATE: August 8, 2011 LOCATION: Chico, CA

Participants

10	Consumers/Family Members/Consumer Advocates
20	Providers
16	County Representatives
07	Other
24	Phone Participants
77	**Total Participants**

Based upon today's presentation, what are the changes in mental health at the state level that stand out for you?

- Counties are dependent on MHSA funds, how will MHSA funds be allocated?
- What kind of advocacy for Older Adults will exist for Aging Community as a result of the elimination of the Department of Aging?
    - [What will be the] representation at the State Level?
- With MHSA the consumer/family voice was heard at the state level, [I am] worried that consumer/ family member voice will be "squashed" again.
- Is the report relevant to African American community? How?
    - What will happen to the African American CRDP Population Report and all the strategies the community defined as a best practice to bring them to wellness?
    - Worried about the relevancy of the report if it just sits on the shelf and none of the community defined evidence is implemented and evaluated.
- I am concerned about the elimination of the Office of Multicultural Services. It needs to continue.
- Programs/functions to be transferred to the county level, but is funding going to the counties to support the work. Will there be training/information for stakeholders?
- Housing component will stay at DMH, but CSH funding/contract is not available. How will Housing continue without them? I am worried about continued technical assistance. I hope that the Housing programs will continue to be supported.
- Can DMH create a chart that shows the proportion of DMH resources (staff, budget, etc.) that supports the function? It will help stakeholders to make decisions about the functions.
- Concerns around California Reducing Disparities Project and where it will go and what will come of the reports each Strategic Planning Workgroup is completing right now. We want it to continue and ultimately make a difference.
- Youth/TAY will inherit whatever the changes are that made now. It is a good time to involve youth, so that youth have more opportunities.
- Continue to support employment for consumers/family members.
- What about the Office of Patient's Rights? Will it be moved?

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What opportunities do you see as a result of the transition at the state level?

Consumers/Family Members/Consumer Advocates

- More local control with focus – hopefully with local Mental Health Boards and Commissions.
- Parity – mental health aligned with health care
- More opportunities for collaboration with PIER
  - -PEER Recovery Model
  - -If at the local level, it may help voices be heard.
- Accessibility is important – Accessibility and communication of services/issues/information
- Budget transparency = knowing where every dollar is going
- More partnerships with Aging groups and regional centers
- Need and opportunity for accountability within communities
  - -People working together, not relying on state
  - -Empowers community to improve
- More opportunities for youth engagement
- Consumer dialogue with the State – How do we keep the consumer voice at the state level?
- Opportunities for cultural competency, offer more opportunities for diverse populations.
- Opportunity to engage stakeholder directly
- Togetherness
- Pay attention to youth issues – racial, queer justice, liberation as it intersects with mental health
- Who will speak for community in the new reality?
- Realistic measurement based on communities needs that will drive services.
- Chance to "get it right!"
- Opportunity for others to come to the table to provide input
- Want to ensure racial disparity reports get seen and acted upon
- Integrated system

County Representatives

- Consumers want to affect policy at higher level. Whom do they go to influence policy?
- Bringing enforcement/documentation in-house is a good opportunity. We are spending time trying to anticipate auditors (gathering documentation, treatment plans). It would be wiser to spend time seeing clients and not worry about documentation standards.
  - Base documentation on Medicaid [or other] Federal standards to make it simpler
  - Consumer driven or case-manager driven efforts for documentation.
- Counties spend too much time re-interpreting DMH Information Notices. This is especially challenging for small counties. Control is the heart stone over MHSA, get oversight to the local level. Make sure funds are kept at the local level.
  - More organic process – opportunity to really hear from county boards. Break open "cubbies" of requirements
- There are a tremendous number of functions now at DMH – concerned something will fall through the cracks.

- Stigma Reduction should stay at state level. Funds available at state level, Counties don't have funds for advertising.

- Streamline extra bureaucratic layers that use up funds
- Pot of MHSA funds will get smaller, [we need to find] a fair and equitable way to split funds to counties. Not all of the money should go to Los Angeles, smaller counties are concerned.
- Timely payments to counties
    - Baseline vs. caseload growth
    - Cost settlements distribution-can't float the funds.
    - Locals pay their bills on time. Why doesn't state pay in timely manner? MHSA is fine, but [I am] concerned about Realignment
- Opportunity for relationship between county and state – to clarify the relationship. More cooperative – less enforcement.
- Protections so that counties don't redirect funds if they don't think mental health is important.
- There is a concern that counties will get told, "you shouldn't have done that" after services have been provided rather than receiving the "blessing" before services begin.
- Fiscal regulation is a very hard process. If it hadn't been so difficult, reversion wouldn't have been a problem. Reversion worked against counties due to the strict regulatory requirements of DMH.

Providers

- Integrate services with a balanced service delivery model. In other words, don't have more resources going to one type of service more than another.
- Reduce paperwork/eliminate duplication
    - Outcomes/billing/AVATAR
- Services to full family = not just the client but a full array of services for the family as well.
    - Local Option
- Decision making authority at the local level
- Diversity across family and systems
- Statewide – continue funding and programs
- The Housing program should stay with DMH for oversight
    - Streamline communication
    - Long term program
    - Supportive services

What do you believe are the challenges associated with the changes to mental health at the state level? How can these challenges be addressed?

- Make sure things don't fall through the cracks.
- Maintain institutional memory of how things happen (i.e., DMH and system in general), this is not the first time that there has been major change. What will happen to people in poor communities? There is some ongoing memory of what is happening right now, some continuity of history.
- History of cross training with county and CalHFA, maintain the momentum of affordable housing – maintain network and partnerships, knowledge may get lost.
- When we talk about challenges we have to be realistic and remember that there is going to be havoc.
- Keeping alive the core of the things we learned through MHSA will help us through this transition.
- How to make the change work: keep hope alive, positivity, look to the future.
- Maintain some oversight: educational rather than punitive with clear expectations.
- Getting stuck and blaming the state- we need to start building community accountability.
- Continuing state and local collaboration.
- Focus on collaboration across regions to include people outside the public mental health system.
- One of the challenges is to be thoughtful about how we maintain the integrity of behavioral/mental health
- Combine similar functions across state agencies. Cross train at the state agencies to perform the function. Eliminate the silos to help reduce stigma and discrimination.
- Don't forget the providers and clients. Continue to inform them, keep them "in the loop" through full inclusion and communication.
- It will be a challenge to advocate for mental health programs that will be integrated. No single voice.
- [Stakeholder meeting] notices need to be sent out earlier. Maybe have opportunity to get information from this region.